Bureau of Health Care Quality & Compliance

for accepted PRINTED: 09/23/2009
11/23/09 B. LAVARAGE HESTIT

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS2128HOS		B. WING		08/27	7/2009
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, S	TATE, ZIP CODE		
DESERT	WILLOW TREATMEN	NT CENTER	6171 W CHA	ARLESTOI 5, NV <del>-8910</del>	NBLVD, Blog , #17 289146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S 000	000 Initial Comments			s 000	S 060 – Quality Improvement		
	a result of a State li complaint investiga on 08/24/09 and fin	Deficiencies was gen- icensure focused sur- tion conducted in you alized on 08/27/09, in	vey and ur facility า		Desert Willow Treatment Center (DWTC) ensure that the hospital has an effective, comprehensive quality improvement proevaluate the provision of care to its patient	gram to	
	Chapter 449, Hospi	evada Administrative itals. 22688 was substanti			<ol> <li>DWTC, through its Quality Assurance Department, will indicate, track, trend, int preventive strategies, and provide innovate alternatives to improve the process of usin chemical restraints.</li> </ol>	ed	11/20/09
	(See Tags S0320,S Complaint #NV0000 deficiencies cited. (See Tag S0320) A Plan of Correction	60325,S0328,S0329) 22683 was substantion n (POC) must be subte to the care of all p	ated with		The Quality Assurance Specialist will enh tracking method of chemical restraints by identifying specific trends and factors precand resulting from chemical restraints. In so, the Quality Assurance Specialist will co consult with the Medical Director and I of Nursing (DON) to operationally define and factors related to chemical restraints.	cipitating doing ontinue Director	11/20/09
	and prevent such o intended completion	ccurrences in the fut n dates and the meci re ongoing complian	ure. The hanism(s)		The identification of specific trends and far related to chemical restraints will assist D developing preventive strategies and alten for improving the process of using chemic restraints.	WTC in natives	12/31/09
	on-going compliand requirements.  The findings and co by the Health Divisi	onclusions of any invition shall not be const	estigation rued as	-	The Quality Assurance Specialist will repidentified trends and factors resulting from chemical restraints to the monthly Leaders Executive Team (LET) meeting. LET will data to determine preventive strategies an alternatives for improving the process of the chemical restraints.	n ship ł utilize d	01/29/10
2	actions or other cla	ninal or civil investiga ims for relief that ma rty under applicable f	y be		The policy and procedures pertaining to c restraints were revised to improve the prousing chemical restraints.	hemical cess of	10/15/09
	Ū	encies were identifie			A series of mandatory staff in-services we conducted at DWTC to include retraining improving the current process of using ch	and	10/29/09
S 060 SS=F	NAC 449.3152 Qua	•		S 060	restraints.	1	
		ody of a hospital shai s an effective, compi					
deficiencie	s are cited, an approved i	plan of correction must be	returned within	10 days afte	er receipt of this statement of deficiencies	3.	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER JUPPLIER REPRESENTATIVE'S SIGNATURE

HPKN11

HOGGEN MANUAGEN

TITLE

(X6) DATE

10/29/09

HPKN11

Linical Program Maragen

TL

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING **NVS2128HOS** 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , BLAG. # 17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV-89102 39146 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 060 S 060 Continued From page 1 2. The Quality Assurance Specialist has begun to 11/13/09 improve and build upon the process of tracking quality improvement program to evaluate the patient injuries during Conflict Prevention and provision of care to its patients. Response Training (CPART) holds and seclusions. The method is improving from tracking whether or This Regulation is not met as evidenced by: not an injury had occurred to tracking specific Based on interview, document review and chart types of injuries (i.e., leg, ann, shoulder, rug burn, review the facility failed to ensure there was an etc.). effective, comprehensive quality improvement program to evaluate the provisions of care for its 12/04/09 The Quality Assurance Specialist will report the patients as follows: specific types of injuries to the monthly LET meeting. LET will utilize data to determine preventive strategies and to assist in developing a 1. The facility did not indicate, track, trend, plan for reducing the number of restraints. introduce preventive strategies or provide innovated alternatives to improve the process of 3. DWTC will provide readily retrievable records 11/13/09 using of chemical restraints. of all denials of patient's rights per policy. The Quality Assurance Specialist will track denial of 2. Patient injuries during Conflict Prevention and rights and all denial of rights forms will be filed along with its specific incident. Response Training (CPART) Holds/Seclusion were not tracked nor trended. 11/19/09 Note: During the September 17, 2009 meeting of the Commission on Mental Health and 3. The facility was not able to provide readily Developmental Services, this body committed to retrievable records of all denials of patient's rights discuss the Seclusion and Restraint Emergency in accordance with the facility's Patient's Rights Procedures form in relation to patient denial of rights at their next meeting scheduled for Policy #2.01 originally effective 1/1/2005 with a November 19, 2009. If the intent of the revision date of 12/07 Section III, M. Commission is to continue to utilize the form as a denial of rights, then a request will be made to 4. The facility did not have a an effective way to include "Denial of Rights" in the title of the form. The Commission's authority regarding denial of evaluate their incident investigation process to rights is set forth in NRS 433.534. DWTC will ensure the safety and protection of their patients. follow the guidance of the Commission and the Attorney General's Office regarding the reporting 6. The facility had no documented evidence of a requirements and the Commission's decisions per plan to reduce the number of chemical and their statutory authority. physical restraints. 4. DWTC is developing a more effective and 11/30/09 efficient way to evaluate its incident investigation Severity: 2 Scope: 3 process to ensure the safety and protection of all

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

SS=D

S 216 NAC 449.340 Pharmaceutical Services

state and federal laws.

2. The pharmacy and area for drug storage must

be administered in accordance with all applicable

This Regulation is not met as evidenced by:

S 216

patients.

The Quality Assurance Specialist has been

investigations. Identified staff involved in an

investigation are quickly moved to another unit,

prioritizing and expediting all incident

09/08/09

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD, Blodg. #17 LAS VEGAS, NV-89102 90 1114 LAS VEGAS, NV-89102 89146 **DESERT WILLOW TREATMENT CENTER** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) placed on administrative duties, or placed on S 216 | Continued From page 2 S 216 administrative leave, depending on severity of Based on observation, interview and policy and incident. All identified witnesses (including patients) are interviewed, and all proper authorities procedure review the facility failed to ensure are informed of incident per policy time frames. psychotropic medication was kept secured in a Report summarizing investigation is completed in locked storage area in accordance with an expedited fashion and disseminated to all proper applicable state and federal laws. authorities. 11/30/09 Severity: 2 Scope: 1 DWTC will continue to refine its incident investigation process and revise policies to reflect an effective means to ensure the safety and S 297 NAC 449.361 Nursing Service S 297 protection of all patients. SS=F 8. The chief administrative nurse shall define the 6. DWTC is developing a plan to reduce the 01/29/10 policies, procedures and standards relating to the number of chemical and physical restraints. provision of nursing services and shall ensure that the members of the nursing staff carry out CPART courses for certification and recertification 09/30/09 were reviewed and revised to ensure the protection those policies, procedures and standards. The of all patients. policies, procedures and standards must be documented and accessible to each member of CPART courses include increased practice and role 10/29/09 the nursing staff in written or electronic form. The modeling (return demonstration) of all approved chief administrative nurse must approve each CPART holds. Courses also include increased element of the policies, procedures and emphasis on preventive techniques and destandards before the element may be used or put escalation content (proactive intervention). into effect. Policies, including the Incident/Accident Reporting 10/15/09 policy and Restraint/Seclusion of Patients policy, This Regulation is not met as evidenced by: were revised for heightened clarity and for the Based on interview, record review and document protection of all patients. review the chief administrative nurse failed to ensure members of the nursing staff consistently 10/29/09 A series of mandatory staff in-services were followed the facilities restraint and suicide conducted at DWTC to include retraining on prevention policies and procedures for 9 of 11 policies, emphasis on preventive and de-escalation patients. (Patients #1, #2, #3, #4, #5, #6, #7, #8, techniques, and use of chemical and physical restraints. and #9) The Quality Assurance Specialist will be tracking 1. Nursing staff failed to consistently obtain 01/29/10 and reporting specific trends and factors pertaining physicians' orders for all instances of physical to chemical and physical restraints, including and chemical restraint use. involved patients and staff, type of injuries, type of holds, etc. This data will be utilized to determine preventive strategies, alternatives, and a plan to 2. Nursing staff failed to document all instances reduce the number of chemical and physical of physical and chemical restraint use on the restraints. facility's "Restraint Incident Report" form.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

HPKN11

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING \_ NVS2128HOS 08/27/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg.#11 LAS VEGAS, NV 89102 89 146 DESERT WILLOW TREATMENT CENTER PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 297 Continued From page 3 S 297 01/29/10 The Clinical Program Manager II (CPM II) will monitor and ensure that DWTC has an effective, Nursing staff failed to consistently complete a comprehensive quality improvement program to "Denial of Rights for Persons with Mental Illness" evaluate the provision of care to its patients. for all instances when patients were placed in physical restraints and when chemical restraints S 216 - Pharmaceutical Services were used. 08/27/09 DWTC has ensured that all medications, particularly psychotropic medication, are kept 4. Nursing staff failed to consistently complete a secured in a locked storage area in accordance with "Restraint and Seclusion Debriefing and Positive applicable state and federal laws, as well as Behavior Intervention Plan" for all instances of DWTC's policies and procedures. physical and chemical restraint use. All medications on each of the five hospital units 08/27/09 5. Nursing staff failed to document the are locked in the medication cart that is also locked consistently "Reasons and Results" for all IM and secured within each unit's medication room. PRN (intramuscular as needed) medications. 08/27/09 All medications in the hospital's central medication room are locked in the after-hour 6. Nursing staff failed to consistently ensure a medication carts that are also locked and secured physical assessment was completed and within the central medication room. documented for each occurrence of physical 10/08/09 restraint. To monitor compliance that all medications are secured in a locked storage area, a Rounding Sheet 7. Nursing staff failed to consistently contact the completed by nurse supervisors has been implemented. This includes direct observation of parents or legal guardians when suicide secured medications on each unit (at least 2x per precautions were initiated per the facilities shift @ random times). If any medication is found Suicide Prevention policy. unsecured, there will be immediate follow-up of corrective procedures. Rounding Sheet is reviewed daily by DON and CMP II for oversight Severity: 2 Scope: 3 and compliance. S 298 S 298 NAC 449.361 Nursing Service 10/09/09 To monitor compliance that all medications are SS=D secured in a locked storage area, a Medication 9. A hospital shall ensure that its patients receive Room Checklist completed by nurse supervisors each shift has been implemented. The checklist proper treatment and care provided by its nursing monitors that the central medication room door is services in accordance with nationally recognized locked and secured, the after-hour medication carts standards of practice and physicians' orders. are locked and secured, and two nurse signatures were obtained for medications used from afterhours carts. If any medication is found unsecured or removed without two nurse signatures, there This Regulation is not met as evidenced by: will be immediate follow-up of corrective Based on record review, the facility failed to procedures. Medication Room Checklist is ensure the nursing staff had the knowledge to reviewed daily by DON and results reported operate an aerosol machine for 1 of 11 patients. (Patient #9)

Bureau of Health Care Quality & Compliance

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		152,111110,1110111101		A. BUILDIN		€.	
		NVS2128HOS				08/27/2009	
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
DESERT	WILLOW TREATMEN	IT CENTER	6171 W CI LAS VEGA	HARLESTOI AS, NV <del>8910</del>	NBLVD, Blody. #17 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETE	
S 298	Continued From pa	ge 4		S 298	weekly to CPM II.		
					S 297 – Nursing Service	ļ.	
S 318 SS=F	Severity: 2 Scope: 1  S 318 NAC 449.3626 Rights of Patient			S 318	The DON will ensure members of the nu consistently follow the hospital's restrain suicide precautions policies and procedur patients (Patients #1, #2, and #3 were dispatients (Patients #1, #2, and #3 were dispatients #1, #2, #3, #3, #3, #4, #3, #4, #3, #4, #3, #4, #3, #4, #4, #3, #4, #4, #4, #4, #4, #4, #4, #4, #4, #4	nt and res for all scharged;	
	policies and proced the rights of patient to 449.730, inclusiv This Regulation is	not met as evidence	d support 3 449.700 d by:		Patients #4, #5, #6, #7, #8, and #9 remain inpatient treatment at DWTC). Restraint suicide precautions policies and procedulupheld for all patients and monitored by supervisors for compliance, particularly medical records of Patients #4 - #9.	t and res will be nurse	
	This Regulation is not met as evidenced by: Based on interview, document review, and record review the governing body failed to develop policies regarding chemical restraints that were in compliance with NRS 433.5503 and failed ensure the facility protected the rights of patients in accordance with facility policies pertinent to patient rights (Reporting of Denial of Rights and Restraint//Seclusion of Patients) for 9 of 11 patients (Patients #1, #2, #3, #4, #5, #6, #7, #8, and #9) as follows:		elop at were in ed ensure		Administration and nurse supervisors restraint and suicide precautions policies procedures through clinical meetings, su and shift change.	and	
18			nt to ghts and f 11		Nursing staff will consistently obtain phyorders for all physical and chemical restrictions hospital policy. Nursing staff will considuce document all physical and chemical restrictions are medical records and through the Incident/Accident Report, Seclusion and Emergency Procedures Denial of Rights	raints per stently raints in e use of an I Restraint form, Pain	
	pertinent to Patient	to consistently follo Rights (i.e. Reportin			Assessment form, and the Restraint and Debriefing & Positive Behavior Interven	ntion Plan.	
	Denial of Rights; Pa Restraint/Seclusion				Nursing staff will consistently complete rights form for all instances when patien placed in physical restraints and when cl	its are	
		icies regarding chem in compliance with N			restraints are used.  Note: During the September 17, 2009 m the Commission on Mental Health and		
	3. The facility did no (DOR) for chemical	ot complete Denial o restraints.	f Rights		Developmental Services, this body communication discuss the Seclusion and Restraint Emerication to patient derights at their next meeting scheduled for	ergency enial of	
	4. The completion of physical restraint are	of a DOR was incons nd seclusion.	sistent for		November 19, 2009. If the intent of the Commission is to continue to utilize the denial of rights, then a request will be minclude "Denial of Rights" in the title of	form as a nade to	
	5. The completion of contain all the requi	of the DOR forms fail ired information.	led to		The Commission's authority regarding of		

08/27/2009

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2128HOS

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## **DESERT WILLOW TREATMENT CENTER**

6171 W CHARLESTON BLVD , Bldg. #17 LAS VEGAS, NV 89102 89146

	LAS VEGI	AS, NV - <del>8910</del>	89146	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 318	Continued From page 5 6. The facility failed to ensure DOR forms were completed when patients on suicide prevention could not wear their own clothing.	S 318	rights is set forth in NRS 433.534. DWTC will follow the guidance of the Commission and the Attorney General's Office regarding the reporting requirements and the Commission's decisions per their statutory authority.	
	7. The facility failed to ensure DOR forms were completed when patients on suicide prevention had their mattresses placed on the floor of the hall.		Nursing staff will consistently document the reasons and results for all IM PRN (intramuscular as needed) medication. The reasons and results will be documented on the back of the Medication Administration Report (MAR) and in the patient's medical record.	10/29/09
	8. The facility did not conduct thorough investigations after incidents to ensure patients were protected and free of abuse and/or neglect.  Severity: 2 Scope: 3	19	Nursing staff will consistently complete and document a physical assessment for each occurrence of physical restraint. This will be documented on the Incident/Accident Report and in the patient's medical record.	10/29/09
S 320 SS=G	NAC 449.3628 Protection of Patient  1. A governing body shall develop and carry out policies and procedures that prevent and prohibit:  (a) Verbal, sexual, physical and mental abuse of patients	S 320	Nursing staff will consistently contact the parents or legal guardians when suicide precautions are initiated per policy. This will be documented on the Incident/Accident Report.  2. Administrators, supervisors, and peer trainers conduct staff in-service/training to ensure	10/29/09
	This Regulation is not met as evidenced by:  Based on interview, record review and document		compliance with hospital's restraint and suicide prevention policies.  Retrain staff on Seclusion and Restraint policies	10/29/09
	review the facility failed to carry out policies and procedures that prevented and prohibited the physical abuse for 3 of 11 patients (Patients #1, #8, and #9).		(including use of denial of rights).  Retrain staff on Incident/Accident Reporting policy.	10/29/09
	Findings include:		Retain staff on Suicide Precautions policy.	11/25/09
	Patient #1 Patient #1 was a 13 year old white juvenile		Monitor compliance that the DON ensures members of the nursing staff consistently follow the hospital's restraint and suicide precautions policies and procedures for all patients.	
	admitted to the facility on 2/3/09 with diagnoses that included bipolar disorder, oppositional defiant disorder and impulse control disorder. The patient was discharged from the facility on 7/23/09.		Mandate review of all policies pertaining to restraint and suicide precautions policies (annual and upon each revision).	11/25/09

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING \_ **NVS2128HOS** 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Bldg.#17 LAS VEGAS, NV 89102 89146 **DESERT WILLOW TREATMENT CENTER** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 10/29/09 S 320 \$320 Continued From page 6 Create and institute signed Statement of Understanding of having read, understood, and Patient #1 reported on 6/15/09, that he was will adhere to all policies and procedures pertaining to restraints and suicide precautions. physically abused by Employees #7 and #8 who twisted the patient's arm behind his back and 10/15/09 Develop database to track signed statements. pushed the patient up against a wall in the facility gym. The patient complained of pain in his arm 10/08/09 as a result of the action by the two employees of Rounding Sheet completed by nurse supervisors has been implemented. This includes the the facility. monitoring on each unit (at least 2x per shift @ random times) of documented physician orders and reasons and results for all IM PRN medication. If Residential Treatment Center Services Continued any errors are found, there will be immediate Stay Request Note dated 6/18/09 indicated the follow-up of corrective procedures. Rounding patient was restrained on 6/15/09 for physical Sheet is reviewed daily by DON and CPM II for aggression towards a peer. The assessment was oversight and compliance. completed by Employee #6. Nurse supervisors receive from unit charge nurses 09/21/09 On 8/25/09 at 10:20 AM, an interview was completed Incident/Accident Report, Seclusion conducted with Employee #6 who reported and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Patient #1 complained on 6/15/09, that he was Restraint and Seclusion Debriefing & Positive grabbed by Employee #7 and Employee #8 who Behavior Intervention Plan for each restraint by the twisted his arm behind his back and pushed him end of shift incident occurred. Forms are reviewed up against a wall in the facility gym. Employee #6 for accuracy and completeness, including the documentation that parents or legal guardians were reported the patient was very upset when he contacted when suicide precautions were initiated. spoke about the incident and complained that his If any error is detected, there will be immediate arm hurt. He asked both employees to stop follow-up of corrective action. Forms are restraining him, but it felt like a long time passed submitted daily to DON for review and oversight. before both employees released the restraint hold. Employee #6 reported the patient 09/16/09 The Quality Assurance Specialist will compare complained of pain in his shoulder and an x-ray patient progress notes with database that contains all submitted Incident/Accident Reports and was completed to rule out an injury. Employee #6 Restraints/Seclusions for accurately capturing and reported that she believed the incident occurred appropriately documenting all incidents. Twenty and assisted the patient in filling out a complaint patient cases will be randomly selected per quarter. about the incident which was submitted to Discrepancies will be brought to the attention of the CPM II within one business day for further Employee #2.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

An incident report by Quality Assurance dated

7/30/09 indicated Patient #1 made an allegation of physical abuse from two staff members that

was reported to Child Protective Services (CPS).

An internal investigation was being conducted by

Employee #2.

investigation and corrective action if necessary.

DWTC will ensure nursing staff has the knowledge

to operate an aerosol machine, as well as any other

equipment/machine used by nursing staff.

S 298 - Nursing Service

Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING **NVS2128HOS** 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Bldg.#17 LAS VEGAS, NV -89102 89/46 DESERT WILLOW TREATMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 09/04/09 S 320 Continued From page 7 S 320 In further exploring this issue, it was determined that the aerosol machine was malfunctioning On 8/25/09 at 1:20 PM, an interview was causing the nurse to mistakenly assume she was not using it properly. The DON will ensure that conducted with Employee #2. Employee #2 nursing staff has the knowledge and training to reported she spoke with Employee #8 after operate all hospital nursing equipment and will receiving a complaint about Patient #1 being ensure that all nursing equipment is in operating physically restrained by Employee #7 and condition. Patient #9's asthma symptoms are presently controlled by the use of an albuterol Employee #8. Employee #2 reported she told inhaler 2x per day, and she is medically assessed Employee #8 she was processing a complaint by the hospital's pediatrician. The aerosol about the incident where Patient #1 was held machine is not currently a part of this patient's against the wall with his arm behind his back in treatment regime. the facility gym. Employee #8 confirmed the incident had occurred in the gym and told S 318 - Rights of Patient Employee #2 the patient was trying to run out of 10/29/09 the gym and she had to stop him from leaving the DWTC has revised policies regarding chemical gym. Employee #2 reported, after requesting and restraints and are in compliance with NRS 433.5503. DWTC will ensure the protection of receiving a written statement about the incident rights for all patients in accordance with policies from Employee #8, she was shocked that pertinent to patient rights (Reporting of Denial of Employee #8's written statement was different Rights and Restraint/Seclusion of Patients) (Patients #1, #2, and #3 were discharged; Patients from the verbal statement given to her earlier. #4, #5, #6, #7, #8, and #9 remain in inpatient Employee #2 reported Employee #8's written treatment at DWTC). Patient rights will be upheld statement made no mention of physically for all patients and monitored by nurse supervisors restraining the patient with his arm behind his for compliance, particularly the medical records of back. The statement indicated the patient was Patients #4 - #9. redirected and accompanied to a matted area where he was given teaching interaction and 1. Administration and supervisors enforce policy to ensure patient rights are upheld through clinical verbal reassurance until he was calm. meetings, supervision, and shift change. Employee #2 reported she conducted an 10/29/09 Staff members will consistently follow policies investigation of the incident and obtained pertinent to patient rights (Reporting of Denial of statements from Employee #6, Employee #7, Rights; Patient Rights; Restraint/Seclusion of Employee #8, and Employee #9 and felt the Patients). Staff members of DWTC have been informed and will comply with all policies and incident involving a physical restraint did occur. procedures pertaining to patient rights. State Employee #2 acknowledged the facilities abuse personnel procedures and disciplinary action will policy and procedure was not followed. follow violations. Employee #2 reported the suspected abuse was not reported to law enforcement and no Policies and procedures regarding chemical 10/15/09 witnesses to the alleged physical abuse were restraints have been revised and are in compliance with NRS 433.5503. Staff members of DWTC interviewed because the facility's Clinical have been informed and will comply. Program Manager thought interviewing patients would be disruptive to the milieu. Employee #2 acknowledged neither employee involved in the

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

HPKN11

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 08/27/2009 NVS2128HOS STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Bldg. #17 LAS VEGAS, NV 89102 89 116 **DESERT WILLOW TREATMENT CENTER** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)1D (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Denial of Rights form will be consistently 10/29/09 S 320 S 320 Continued From page 8 completed and will contain all required suspected abuse of the patient was placed on information for all chemical restraints, physical restraints, and seclusions. administrative leave following the incident and the patient was never transferred to another program 11/19/09 Note: During the September 17, 2009 meeting of to ensure the patient's proper care and the Commission on Mental Health and protection. Developmental Services, this body committed to discuss the Seclusion and Restraint Emergency On 8/24/09 at 12:00 PM, an interview was Procedures form in relation to patient denial of rights at their next meeting scheduled for conducted with Employee #8. Employee #8. November 19, 2009. If the intent of the denied any Conflict Prevention and Response Commission is to continue to utilize the form as a Training (CPART) restraint holds were applied to denial of rights, then a request will be made to Patient #1 in the gym on 6/15/09. Employee #8 include "Denial of Rights" in the title of the form. indicated she and Employee #7 were observing The Commission's authority regarding denial of rights is set forth in NRS 433.534. DWTC will 12 patients in the gym area when she observed follow the guidance of the Commission and the Patient #1 velling at a peer in the gym and asked Attorney General's Office regarding the reporting him to take a time out. Patient #1 started yanking requirements and the Commission's decisions per their statutory authority. at the railing and at one point started walking towards the door of the gym in an attempt to 11/25/09 leave. Patient #1 was verbally redirected to a Denial of Rights form will be consistently completed for all patients when on suicide matted area of the gym. Employee #8 reported precautions and not able to wear their own clothing the patient complied with verbal directions and at or when mattress is placed on the floor of the hall. no time were any CPART restraint holds placed Administration will also revise Suicide Precautions on the patient. Employee #8 reported she never policy to better clarify and resolve above concerns. physically touched the patient during the redirection. Employee #8 indicated she reported The Quality Assurance Specialist has been 09/08/09 prioritizing and expediting all incident the patient's behavior to the charge nurse once investigations. DWTC is conducting thorough the patients were returned to the unit. Employee investigations to ensure patients are protected and #8 reported she had completed a CPART course free of abuse and/or neglect. Identified staff as part of her facility training and grabbing a involved in an investigation are quickly moved to patient's arm and twisting it behind his back while another unit, placed on administrative duties, or placed on administrative leave, depending on restraining the patient against a wall would not be severity of incident. All identified witnesses an authorized or approved CPART restraint. (including patients) are interviewed, and all proper authorities are informed of incident per policy time A typed incident report from Employee #8 dated frames. Report summarizing investigation is completed in an expedited fashion and 8/1/09 documented an incident on 6/15/09 where disseminated to all proper authorities. Patient #1 displayed verbal aggression toward a certain male peer in the facility gym. Staff

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

intervened and asked Patient #1 to take a time

#1 walked over to the bleachers and started yanking at the railing and kicking the bleachers

out by asking him to sit on the bleachers. Patient

2. Administration, supervisors, and peer trainers

conduct staff in-service/training to ensure patient

rights are upheld.

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING **NVS2128HOS** 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD, Blog. #17 LAS VEGAS, NV 89102 89146 DESERT WILLOW TREATMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) Retrain staff on Seclusion and Restraint policies 10/29/09 S 320 Continued From page 9 S 320 (including use of denial of rights). and attempted to walk out of the gym. Staff 10/29/09 redirected the patient to a matted wall area where Retrain staff on Incident/Accident Reporting he was given teaching interaction and verbal policy. assurance until he was calm. Patient #1 then returned to the bleachers where he sat until the 11/25/09 Retrain staff on Patient's Rights policy (including gym time expired. Patients and staff members use of denial of rights). then returned to the unit. The incident was 11/25/09 Retrain staff on NRS Patient Rights 449.700 reported to Employee #9. 449,730. A Communication Log entry dated 6/15/09 11/25/09 Retrain staff on Suicide Precautions policy. indicated Patient #1 had verbal and physical aggression telling a male peer to, "shut the (F) 3. Monitor compliance that patient rights are up" and refusing to follow instructions, kicking upheld. bleachers, yanking railing around on bleachers, yelling at staff." (There was no documentation of 10/29/09 Mandate review of all policies pertaining to patient a CPART or physical restraint use on the patient.) rights (annually and upon each revision). On 8/25/09 at 1:00 PM, Employee #9 was Create and institute signed Statement of 10/29/09 interviewed regarding the alleged restraint of Understanding of having read, understood, and Patient #1 on 6/15/09 in the facility gym by will adhere to all policies and procedures Employee #7 and Employee #8. Employee #9. pertaining to patient rights. reported she was informed about the patient's 10/15/09 verbal and physical aggression in the gym by Develop database to track signed statements. both employees, but was not informed either employee ever restrained the patient. Employee Rounding Sheet completed by nurse supervisors 10/08/09 has been implemented. This includes direct #9 indicated the patient did not complain of observation of patient rights being upheld on each shoulder pain when he returned to the unit on unit (at least 2x per shift @ random times). If any 6/15/09 and was not medicated for pain. denial of rights is observed, there will be Employee #9 reported the patient complained of immediate follow-up of corrective procedures. Rounding Sheet is reviewed daily by DON and shoulder pain a week later and the physician was CPM II for oversight and compliance. called and an x-ray order was obtained for the patient's right shoulder. Employee #9 indicated 09/21/09 Nurse supervisors receive from unit charge nurses she was distracted and forgot to write the order completed Incident/Accident Report, Seclusion for the x-ray in the patients chart. Employee #9

reported, when she questioned Patient #1 about

Employee #7 and Employee #8 tried to stop him

from leaving the gym on 6/15/09 and grabbed

him and held him by his shoulders.

his shoulder pain and injury, he told her that

HPKN11

and Restraint Emergency Procedures Denial of

Behavior Intervention Plan for each restraint and

seclusion by the end of shift incident occurred.

Forms are reviewed for accuracy and

Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Blog . # 17 LAS VEGAS, NV . 89102 89/1/6 DESERT WILLOW TREATMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) completeness, including the completion of a denial S 3201 Continued From page 10 S 320 of rights form for patients on suicide precautions A Nursing Progress Note dated 6/15/09 at 8:21 and not able to wear their own clothing or when mattress is placed on the floor of the hall. If any PM, by Employee #9 indicated Patient #1 took error is detected, there will be immediate follow-up part in all unit activities with a flat affect and labile of corrective action. Forms are submitted daily to mood. "Attended, participated during fitness DON for review and oversight. group, and played volleyball at the gym. He had a good appetite for dinner and snack. He had a The Quality Assurance Specialist tracks consumer 09/25/09 positive phone call from mom. Took evening complaints pertaining to violations of patient rights. Any consumer complaint related to denial medication with no adverse reaction noted. Staff of rights will be immediately investigated. Report will continue to monitor for patient safety and of investigation is submitted to CPM II for comfort. Had VA (verbal aggression) PA (physical corrective action. aggression) telling certain male peer to "shut the f up". Refused to comply with staff 's instructions, The CPM II will monitor and ensure that the 09/08/09 dramatic, negative attention seeking behavior, Quality Assurance Specialist conducts thorough investigations after incidents to make certain all kicking bleachers, yanking railing, around on patients are protected and free of abuse and/or bleachers, yelling at staff, teaching interaction neglect. done with fair acceptance to feedback." S 320 - Protection of Patient A typed statement of the incident dated 8/2/09 from Employee #9 documented no takedown on 10/29/09 DWTC will revise and execute policies and Patient #1 was reported by Employee #7 or procedures that prevent and prohibit verbal, sexual, Employee #8. "The patient was just escorted physical, and mental abuse of all patients (Patient against the wall and given teaching interaction to #1 was discharged; Patients #8 and #9 remain in inpatient treatment at DWTC). The protection of help calm him down. The patient reported he was all patients will be upheld and monitored by taken down a week after the incident. I did not administration, nursing supervisors, the Quality believe him because all the while he was playing Assurance Department, and the Behavior volleyball without complaining of any pain. When Management Team. it was time for fitness group he complained of shoulder pain only before fitness group. Thus 1. Revision of policies and procedures pertaining x-ray was done to validate his complaint which to restraints/seclusion and abuse/neglect for heightened clarity and for the protection of all

patients.

Revise Incident/Accident Reporting policy and

Restraint/Seclusion of Patients policy to clearly

responsible for the documentation and completion of Incident/Accident Report, Seclusion and

Restraint Emergency Procedures Denial of Rights

form, Pain Assessment form, and the Restraint and

specify that charge nurse on each unit is

Seclusion Debriefing & Positive Behavior

10/15/09

If continuation sheet, 11 of 35

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

came out negative."

On 8/25/09 at 3:00 PM, an interview was

conducted with Employee #7 who denied any

6/15/09 in the gym area of the facility. Employee

#7 reported the patient was exhibiting verbal and

physical aggression and was yelling at a peer and

kicking the bleachers and pulling on the railing in

the gym. The patient attempted to leave the gym area and she blocked his path while Employee #8

CPART holds were applied to Patient #1 on

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS2128HOS** 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD, Blog. #17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV -89102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 320 Continued From page 11 S 320 Intervention Plan by the end of shift incident occurred positioned herself on the opposite side of the patient. The patient was verbally directed to a Revise Incident/Accident Report policy to include 10/15/09 padded area of the gym. Employee #7 reported types of physical restraint used, chemical restraint, and locked/unlocked seclusion. at no time did she or Employee #8 place the patient in a CPART hold or physically place their 10/15/09 hands on the patient. Employee #7 indicated she Revise Progress Notation policy to clearly specify that Mental Health Technicians will document in had completed a CPART course as part of her progress notes any restraint for which they may be facility training and twisting a patients arm behind involved by the end of shift incident occurred. his back and restraining the patient against a wall would not be an approved or authorized CPART Revise Reporting and Investigation of Abuse 11/25/09 hold. and/or Neglect of Patients policy to heighten clarity and to mirror NRS 432B. A typed incident report dated 8/14/09, by Employee #7 documented Patient #1 was playing 2. Reviewed and revised CPART certification and recertification courses to ensure the protection of volleyball with his peers and got angry at a fellow all patients. peer and yelled, "shut the f up. "Employee #7 and Employee #8 intervened and asked the Increase practice and role modeling (return 09/30/09 patient to take a time out asking him to sit on the demonstration) of approved CPART holds. bleachers. "The patient stomped over to the bleachers and started yanking at the railing and 09/30/09 Increase the preventive techniques and dekicking the bleachers. The patient attempted to escalation content (proactive intervention) within walk out of the gym. Employee #7 stood in front CPART certification and recertification training. of the gym door. Both employees then redirected and accompanied the patient to the matted area 3. Administration and supervisors enforce policy away from the door. Teaching interactions were to ensure the protection of all patients through clinical meetings, supervision, and shift change. were given to the patient to calm down and take deep breaths. The above behavior was reported Any physical or chemical restraint will be to the R.N." 09/04/09 prescribed by a physician order. On 8/26/09 at 11:35 AM, an interview was The use of any physical or chemical restraint will 09/04/09 conducted with Patient #4. Permission to

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

interview the patient was obtained from the

patient's father prior to the interview. Employee #6, the patients therapist was present during the

incident on 6/15/09 that took place in the gym

incident occurred at 7:00 PM while the patients

were playing volley ball. Patient #4 reported Patient #1 became agitated and angry and

area of the facility. Patient #4 reported the

interview. Patient #4 reported he remembered the

result in reporting the incident as a denial of rights,

Any physical or chemical restraint will be

documented in patients' medical record and through the use of an Incident/Accident Report,

Seclusion and Restraint Emergency Procedures

Denial of Rights form, Pain Assessment form, and

the Restraint and Seclusion Debriefing & Positive

09/04/09

using appropriate form.

08/27/2009

Bureau of Health Care Quality & Compliance

STATEMENT	OF	DEF	ICIEN	CIES
AND PLAN OF	F C	ORR	ECTIO	)N

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING

NVS2128HOS

B. WING \_\_\_\_

NAME OF P	ME OF PROVIDER OR SUPPLIER .			TATE, ZIP CODE	
DESERT	WILLOW TREATMENT CENTER	6171 W C LAS VEG	HARLESTON AS, NV - <del>8910</del>	NBLVD, <i>Bldg.#17</i> * 89146	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 320	Continued From page 12		S 320	Behavior Intervention Plan.	
	verbally yelled at him to "Shut the (F) up #4 reported at one point Patient #1 atter run out of the gym and was physically re by both Employee #7 and Employee #8. #4 reported both employees grabbed Pa	mpted to estrained Patient		Any suspected abuse/neglect will be reported to proper authorities (CPM II, DCFS Deputy Administrator, law enforcement, Child Protective Services, Bureau of Health Care Quality and Compliance) within 24 hours.	09/08/09
	by the shoulders and twisted his arm be back and pushed him up against a wall gym. Patient #4 estimated both employ	hind his in the ees		Internal investigation of incident by Quality Assurance Specialist will be expedited.	09/08/09
	restrained Patient #1 against the wall fo approximately 15 seconds before having on the bleachers.	g him sit		Identified staff involved in an abuse/neglect investigation are quickly moved to another unit, placed on administrative duties, or placed on administrative leave, depending on severity of incident.	09/08/09
	On 8/26/09 at 11:45 AM, an interview w conducted with Patient #2. Permission interview the patient was obtained from patient's mother prior to the interview.	to the		All identified witnesses (including patients) are interviewed.	09/08/09
	#6, the patient's therapist, was present interview. Patient #2 reported he remer the incident on 6/15/09, that took place facility gym. Patient #2 reported the inc	mbered in the		Report summarizing investigation is completed in an expedited fashion and disseminated to all proper authorities.	09/08/09
	place in the evening between 7:15 PM a PM while the patients were playing volle Patient #2 reported Patient #1 became in a verbal argument with another patien	and 8:00 eyball. involved		Administration, supervisors, and peer trainers conduct staff in-service/training for the protection of all patients.	
	yelled, "Shut the (F) up." Patient #2 ind Patient #1 was angry and agitated and a point ran for the door of the gym. Patien	icated at one nt #2		Retrain staff on Incident/Accident Reporting policy (including accurately documenting all persons involved in incident).	10/29/09
	reported Employee #7 and Employee #3 grabbed Patient #1, put his arm behind and slammed him up against a wall in the Patient #2 indicated Patient #1 was rest	his back, ne gym.		Retrain staff on Seclusion and Restraint policies (including use of denial of rights and obtaining physician order).	10/29/09
	both employees against the wall for approximately 4 to 5 minutes.			Retrain staff on NAC 449.3628 – Protection of Patients.	10/29/09
	The facility June 2009 and July 2009 Restraint/Seclusion Log indicated there documented incidents of physical restra			Retrain nursing staff on required documentation of patient injury and any medical care provided.	10/29/09
	seclusion for Patient #1 on 06/15/09 or months of March 2009, April 2009, May June 2009, and July 2009.	for the		Retrain staff on approved CPART holds, preventive techniques, and de-escalation skills.	10/29/09

Bureau o	of Health Care Quali	ty & Compliance				<del>,</del>	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		NVS2128HOS				08/2	7/2009
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
DESERT	WILLOW TREATMEN	NT CENTER	6171 W C LAS VEG	HARLESTO AS, NV <del>8910</del>	NBLVD, Bldg. #17 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S 320	A review of Physicians Orders for Patient #1 failed to reveal evidence of a physician order for physical restraints on 6/15/09, the date of the		S 320	Retrain staff on documentation to medica necessity, objective facts of incident, beh descriptors, precipitating factors, descrip interventions prior to restraint, and type a description of CPART hold.	avioral tion of	10/29/09	
	alleged incident.	·			Retrain staff on Reporting and Investigat Abuse and/or Neglect of Patients policy.	ion of	11/25/09
	indicated an x-ray of	Log entry dated 6/21/ on the patient's right on e x-ray was negative	shoulder		Monitor compliance that patient safety protection is upheld for all patients.	y and	
	The facilities Restra	ion. aint Seclusion Policy ated restraint and se			Mandate review of all policies pertaining restraints and abuse/neglect to ensure the protection of all patients.	to	11/25/09
	shall only be used i measure in situatio patients, staff or otl measures have be	in an emergency safe ns of imminent dang hers when less restri en or likely to be inef	ety er to ctive		Create and institute signed Statement of Understanding of having read, understoo will adhere to all policies and procedures pertaining to restraints and abuse/neglect		11/25/09
	averting danger.				Develop database to track signed statement	ents.	10/15/09
	seclusion included  1. "Physician writte and continued use	e procedure for restr the following: n or verbal orders for of restraints are requed and are not written	r initial iired and		Rounding Sheet completed by nurse sup has been implemented. This includes dir observation of restraints and to ensure the protection of all patients is upheld on each least 2x per shift @ random times). If an issue is observed, there will be immediated.	ect at the th unit (at ny safety e follow-	10/08/09
	orders."				up of corrective procedures. Rounding S reviewed daily by DON and CPM II for and compliance.		
	assessment of the following restraint of		ediately		Nurse supervisors receive from unit char completed Incident/Accident Report, Sec and Restraint Emergency Procedures De Rights form, Pain Assessment form, and	lusion nial of	09/21/09
	of each occurrence a time frame not to		lusion with		Restraint and Seclusion Debriefing & Po Behavior Intervention Plan for each restr seclusion by the end of shift incident occ Forms are reviewed for accuracy and completeness. If any error is detected, the	sitive aint and urred.	
	each episode of re- than 24 hours after the event and plan	nitiate a debriefing fo straint and seclusion the episode in order any future, earlier alt	no longer to review ternative		be immediate follow-up of corrective act Forms are submitted daily to DON for re oversight.	ion.	
	interventions. The	staff member will doo	cument in				

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING **NVS2128HOS** 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD Bldg. #17 LAS VEGAS, NV 89102 89146 **DESERT WILLOW TREATMENT CENTER** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLÉTE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 09/16/09 S 320 Continued From page 14 S 320 The Quality Assurance Specialist will compare patient progress notes with database that contains the patient's record that the parent or guardian all submitted Incident/Accident Reports and Restraints/Seclusions for accurately capturing and has been notified." appropriately documenting all incidents. Twenty patient cases will be randomly selected per quarter. "Facility staff must document all incidents of Discrepancies will be brought to the attention of restraint/seclusion on the Seclusion and Restraint the CPM II within one business day for further investigation and corrective action if necessary. Reporting form." 6. "The leadership staff shall maintain a The CPM II will monitor and ensure that the 09/08/09 Quality Assurance Specialist conducts thorough performance improvement program designed to investigations after incidents to make certain all continuously review monitor and analyze the use patients are protected and free of abuse and/or of seclusion and restraint interventions." neglect. 7. "A formal Interdisciplinary Treatment Team 10/12/09 The Behavior Management Team provides Review will be held for all patients placed in additional oversight of Incident/Accident Report, Seclusion and Restraint Emergency Procedures seclusion or restraints. This shall be documented Denial of Rights form, Pain Assessment form, and in the medical record." the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan. The team meets 8. "The facility Clinical Program Manager II is weekly to review completed forms and monitors for necessity of intervention, appropriate responsible for assuring that on-going documentation, and whether actions were justified. documentation and monitoring of patients placed Any form found with unjust/unnecessary in seclusion and or restraints is maintained." intervention or inappropriate documentation will be returned to the Quality Assurance Specialist for further review or investigation. On 8/24/09 at 2:00 PM, an interview was conducted with Employee #2 who acknowledged 6. Patient follow-up: As noted previously, Patient the findings regarding the investigation into the #1 was discharged from DWTC. The Quality physical abuse incident failed to reveal Assurance Specialist completed the internal documented evidence the physician wrote an investigation on this incident. Final report was order for a physical restraint or CPART hold on submitted to proper authorities. DCFS conducted the date of the incident on 06/15/09. There was a separate investigation for personnel reasons and results remain pending. Employees #7 and #8 no documented evidence the use of a physical remain on administrative leave. restraint on Patient #1 was reported to the charge nurse. There was no documented evidence a Patient #9 was discharged from DWTC and facility restraint incident report was completed recently readmitted to another unit. While law following the use of a restraint on 6/15/09. There enforcement unsubstantiated the abuse allegation, was no documented evidence a Patient Denial of DWTC did not conduct an internal investigation of

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Rights was completed following the incident. The

facility failed to follow policy and procedure by not

complete investigation into the physical abuse incident by not interviewing patient witnesses.

notifying law enforcement or conducting a

incident. The process currently followed at DWTC

is to immediately initiate an internal investigation

of an incident when there is suspect of any

patient/staff complaint or allegation of abuse.

Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Bldg. #17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV-89102 89 146 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) S 320 Continued From page 15 \$ 320 Patient #9 will continue to be monitored for safety. The facility failed to follow policy and procedure As noted previously, Patient #8 remains in by not placing the employees involved in the inpatient treatment at DWTC. He has been abuse allegation on administrative leave pending transferred to another unit since the 8/13/09 CPART hold. Results of investigation remain completion of the investigation. pending. Patient #8 will continue to be monitored for safety. Staff members have been retrained on A review of the facility CPART training records least restrictive interventions, de-escalation revealed both employees CPART certification techniques, and clear documentation to medical was valid until 6/12/10. necessity, objective facts of incident, behavioral descriptors, precipitating factors, description of interventions prior to restraint, and type and A review of the facilities CPART training manual description of CPART hold. Any current last revised 01/05 failed to reveal documented discrepancies with unjust/unnecessary intervention CPART restraint holds that involved twisting a or inappropriate documentation will be submitted to the Quality Assurance Specialist for further patients arm behind the back and restraining a review or investigation. patient against a wall. A review of Patient #1's medical record and staffing schedules revealed Employee #7 and Employee #8 continued to have frequent contact with the patient and be involved in the care and treatment of the patient following the physical abuse restraint incident on 06/15/09 and until the patient's discharge from the facility on 7/23/09. The Facilities Report and Investigation of Abuse and or Neglect of Patients Policy and Procedure last revised 12/07 included the following: 1. Policy: "Physical abuse and/or neglect of patients is unlawful and will not be condoned or allowed in any Division program. Suspected abuse or neglect is to be immediately reported to the supervisor and Clinical Program Manager II. "Abuse and neglect means the non-accidental physical or mental injury, sexual abuse, negligent treatment or maltreatment of an individual under circumstances which indicate that the individual's health or welfare is harmed or threatened thereby." 2. Procedure: The Clinical Program Manager II,

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Blog. #17 DESERT WILLOW TREATMENT CENTER LAS VEGAS, NV 89102 89146 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG **DEFICIENCY**) S 320 Continued From page 16 S 320 or person acting in that capacity upon receiving a report of alleged abuse or neglect will take the following actions: a. "As soon as possible, but within 24 hours of being apprised of suspected abuse or neglect. notify the law enforcement agency with jurisdiction over the incident." b. "Immediately, but in no case longer than 24 hours, notify the Deputy Administrator, Division of Child and Family Services, or the person acting in that capacity, of the incident." c. "As soon as possible, but within 24 hours. notify the patient legal guardian, if one has been appointed of the incident. Notify Child Protective Services." d. "As soon as practical, separately interview witnesses, the alleged victim, and the alleged perpetrator for the purpose of ascertaining the need for immediate action to prevent further abuse or neglect." e. "If the Clinical Program Manager II initially finds physical evidence and /or corroboration witnesses of the reported abuse and neglect, he/she shall notify the appropriate law enforcement agency." f. "If upon preliminary investigation, the Clinical Program Manager II determines the facts surrounding the alleged incident provide reason to believe that the patient is in danger of continued or repeated abuse or neglect,

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

immediate action shall be taken which may

2. "Transferring the patient or staff to another program within the agency to ensure the patient's

1. "Placing the alleged perpetrator on

include:

administrative leave."

proper care and protection."

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING **NVS2128HOS** 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , BLOG. #17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV -89102 89/1/6 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE **TAG** TAG **DEFICIENCY**) S 325 - Physical Restraint Use S 320 Continued From page 17 S 320 Complaint #NV00022688 DWTC will ensure that all policies and procedures pertaining to the use of physical restraints are upheld for all patients (Patient #1 was discharged; Patient #9 Patients #5, #6, #7, #8, and #9 remain in inpatient treatment at DWTC). Nurse supervisors and the Patient #9 was re-admitted to the facility on Quality Assurance Specialist will monitor 7/1/09 with diagnoses including mood disorder, compliance with the use of physical restraints for all patients, particularly the medical records of conduct disorder, alcohol abuse, marijuana Patients #5 - #9. abuse, history of asthma and severe constipation. 1. Administration and supervisors enforce policy On 7/28/09, an allegation was made by Patient to ensure the use of physical restraints are executed #9 of a staff member poking her in the chest. properly through clinical meetings, supervision, The Las Vegas police unsubstantiated the and shift change. allegation of physical and sexual abuse. 09/04/09 The facility failed perform an internal investigation Any physical restraint will be prescribed by a per their Reporting and Investigation of Abuse physician order. and/or Neglect of Patients. The use of any physical restraint will result in 09/04/09 Complaint #NV00022683 reporting the incident as a denial of rights, using appropriate form. Patient #8 All patients are treated and managed in the least Patient #8, a 12 year old male, was admitted on 09/04/09 restrictive manner. Physical restraint will only be 8/7/09, with a diagnosis of mood disorder. The used as an emergency safety measure in situations facility failed to have evidence of an investigation of imminent danger to patients, staff, or others and

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

of the implementation of a CPART hold on

was informed this CPART may have been unnecessary when the child only postured, no

actual assault." A day later the patient

Scope: 1

S 325 NAC 449.3628 Physical Restraint Use

Severity: 3

administration.

8/13/09, after the DON documented "Charge RN

complained of pain in the right shoulder blade.

5. The governing body shall ensure that the use of any physical restraints on a patient is initiated

only pursuant to a physician's order or protocols

approved by the medical staff and the hospital

This Regulation is not met as evidenced by:

SS=I

S 325

10/29/09

09/04/09

when less restrictive interventions have been determined to be ineffective to protect the patient

Nursing staff completes a post intervention

immediately following a physical restraint, and all

assessment as well as a pain assessment

thoroughly documented and completed.

Any physical or chemical restraint will be

documented in patient's medical record and through the use of an Incident/Accident Report,

Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and

the Restraint and Seclusion Debriefing & Positive

items on the forms and within the Restraint/Seclusion of Patients policy are

Behavior Intervention Plan.

or others from harm.

Rureau	of Health Care Quali	ty & Compliance					: 09/23/2009 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION  G	(X3) DATE S COMPLI	
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	00/2	772000
	WILLOW TREATMEN	NT CENTER	0474 184 0		UDIND Alda 417		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S 325	Based on interview review the facility far physical restraints of pursuant to physicial (Restraint/Seclusion dated 1/1/2005 and Reporting of Denial 1/1/2005 and revised Investigation of Abulast revised 12/07) #1, #5, #6, #7, #8, #Interviews throughous health technicians a (Conflict Prevention)	record review and called to ensure the use on patients was initial and sorder and facility of Patients policy #4 reviewed on 7/2006 of Rights #2.02 effeed on 12/2007, and Fuse and or Neglect of for 6 of 11 patients (1 #9).  But the survey with the called the condition of the CP on Response Training aff were to utilize the	se of ted policy 8.03 ctive Report and f Patients Patients e mental ART training	S 325	Seclusion monitoring is performed through continuous, in-person observation for the fi a patient is in seclusion. After the first hou patient may be monitored using video if co with the patient's condition. Seclusion mo is documented in the patient's medical recon the 15-Minute Observation Monitoring Patients who are in seclusion are regularly evaluated every two hours for children age older and every hour for children under age.  Patients who have been restrained or seclustaff members who have participated in the interventions will engage in debriefing eace episode to elicit feedback and information patient and staff about the intervention and for future, earlier, or alternative intervention.  2. Administration, supervisors, and peer the conduct staff in-service/training to ensure restraints and seclusion are properly uphel	irst hour ir, the insistent initoring ord and form. re- s 9 and e 9.  ded and esse th from the it to plan ons.  rainers use of	09/04/09
		that, after a CPART sessment." She rep			Retrain staff on Restraint and Seclusion po (including use of denial of rights).	olicies	10/29/09
	do not document al Restraint/Seclusion	Il items as identified in of Patients policy.	n the		Retrain staff on Incident/Accident Reporti policy.	ng	10/29/09
	Patient #7		-:444		Retrain staff on approved CPART holds, preventive techniques, and de-escalation s	kills.	10/29/09
	7/10/09, with the disorder	ar old male, was admagnoses that include r, history of psychotic lisorder, and history of this disorder.	d c disorder,		Retrain staff on documentation to medical necessity, objective facts of incident, behadescriptors, precipitating factors, descriptinterventions prior to restraint, and type and description of CPART hold.	vioral ion of	10/29/09
	"physical restraint ι	7 AM, a physician's c up to 2 hours for phys facility failed to have	sical		<ol> <li>Monitor compliance that proper use of and seclusion are upheld.</li> </ol>	restraints	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

of an Incident/Accident report, assessment, nor

Denial of Rights (DOR) for this incident.

On 7/24/09 at 5:45 PM, an incident report documented a "10 minute CPART hold." The facility failed to have evidence of a DOR for this revision).

Mandate review of all policies pertaining to restraints and seclusion (annually and upon each 10/29/09

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Blog. #17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV 89102 89/46 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 325 Continued From page 19 S 325 Create and institute signed Statement of 10/29/09 Understanding of having read, understood, and incident or a physician's order for the hold. will adhere to all policies and procedures pertaining to restraints and seclusion. On 7/26/09 at 11:00 AM, an incident report 10/15/09 documented a "2 minute CPART hold." The Develop database to track signed statements. facility did not produce a DOR for this incident or a physician's order for the CPART hold. Rounding Sheet completed by nurse supervisors 10/08/09 has been implemented. This includes direct observation of the use of restraints and seclusion On 7/27/09 at 11:40 AM, a physician's order for a on each unit (at least 2x per shift @ random times). "therapeutic hold" was documented. The facility If any violation of the policies or procedures is did not produce an Incident/Accident report, observed, there will be immediate follow-up of corrective procedures. Rounding Sheet is assessment, nor DOR for this incident. reviewed daily by DON and CPM II for oversight and compliance. On 7/27/09 at 4:30 PM, a physician's order for "CPART hold for at least 30 minutes to keep Nurse supervisors receive from unit charge nurses safe" was documented. The RN notes 09/21/09 completed Incident/Accident Report, Seclusion documented the CPART hold occurred. The and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the facility did not produce an Incident/Accident Restraint and Seclusion Debriefing & Positive report, assessment, nor DOR for this incident. Behavior Intervention Plan for each restraint and seclusion by the end of shift incident occurred. On 8/9/09 8:05 PM, an incident report Forms are reviewed for accuracy and documented a "CPART hold..." The facility did completeness. If any error is detected, there will be immediate follow-up of corrective action. not produce a DOR for this incident. Forms are submitted daily to DON for review and oversight. Patient #8 The Quality Assurance Specialist will compare 09/16/09 Patient #8, a 12 year old male, was admitted on patient progress notes with database that contains 8/7/09, with a diagnosis of mood disorder. all submitted Incident/Accident Reports and Restraints/Seclusions for accurately capturing and appropriately documenting all incidents. Twenty A mental health technician (MHT) progress note patient cases will be randomly selected per quarter. written on 8/13/09, read "I will show you and Discrepancies will be brought to the attention of postured at the nurse!! To hit him and was place

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

hold for physical aggression...'

in CPART hold for 7 minutes." An RN progress

closed fist. CPART hold was implemented. Dr.

order dated 8/13/09 at 4:45 PM read "CPART

The Incident report documented "Action Taken:

was made aware of the incident..." A physician's

note written on 8/13/09 read "He refused to go to Quiet Room, then he postured to hit staff with a

10/12/09

the CPM II within one business day for further

investigation and corrective action if necessary.

additional oversight of Incident/Accident Report,

Denial of Rights form, Pain Assessment form, and

the Restraint and Seclusion Debriefing & Positive

Seclusion and Restraint Emergency Procedures

Behavior Intervention Plan. The team meets weekly to review completed forms and monitors

The Behavior Management Team provides

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Bldg. #17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV 89102 59/4/6 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) S 325 S 325 for necessity of intervention, appropriate Continued From page 20 documentation, and whether actions were justified. CPART hold.... On initial assessment the patient Any form found with unjust/unnecessary intervention or inappropriate documentation will denied pain. A day later the patient claimed of be returned to the Quality Assurance Specialist for pain in the right shoulder blade. No swelling nor further review or investigation. limitation of movement on the involved extremity. He was given Ibuprofen for pain." The DON wrote in the comment section "Charge RN was informed this CPART may have been unnecessary when the child only postured, no actual assault." The debriefing was completed. Documentation indicated the "child could have controlled his anger." There was no documented evidence of a discussion of the possibility of an unnecessary CPART and what the staff could have done differently. There was no "Denial of Rights" completed for the CPART hold. Patient #5 Patient #5, a 16 year old female, had a current admit date on 6/24/09 and a previous admission on 5/7/09. Her diagnoses included bipolar disorder, mixed, severe psychosis, eating disorder, and post traumatic stress disorder. On 5/11/09 at 11:28 AM, an incident documented that a "Therapeutic Hold" was done between 11:28 AM and 11:32 AM. On 5/20/09 at 7:00 PM an incident was recorded as a "5 min CPART hold." The facility failed to have evidence of a physician's order for the CPART hold. On 7/30/09 at 4:00 PM an incident was recorded as a "5 min CPART hold." The facility failed to have evidence of a physician's order for the CPART hold.

Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD, Bldg. #17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV 89102 89/1/6 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 325 Continued From page 21 S 325 Patient #6 Patient #6, a 15 year old male, was admitted on 2/2/09, with the diagnosis of psychotic disorder. On 7/13/09 at 3:55 AM a physician's order read "Place in locked seclusion for up to 1 hour for safety." An incident was recorded on 7/13/09 at 3:25 AM and read "was in seclusion for 30 minutes." A daily 15 minute "Unit Where About Sheet" was presented by the facility as a "Restraint Monitoring" sheet. The Quality Assurance Specialist (QA) reported the "Unit Where About Sheet" was used when monitoring the "Seclusion" room. The form was blocked into in 15 minute increments. The QA reported the staff document "QR" when a patient was in seclusion. She indicated "QR" stood for Quiet Room. She stated the staff also use "QR" when the patient is in the guiet room when the door is unlocked. Review of the the 7/13/09. "Unit Where About Sheet" revealed Patient #6 was in the "QR" from 3:45 AM to 5:15 AM. The 7/13/09 "Unit Where About Sheet" indicated the patient was listed as "QR" in the 8:00 PM section and "QR" in the 8:45 PM to 10:45 PM time sections. The facility failed to have documented evidence "continuous in-person monitoring" occurred for Patient #6. On 7/13/09 at 8:30 PM, an incident was recorded as a "3 person CPART hold..." and on 7/31/09 at 8:10 PM an incident indicated a "CPART hold." The facility did not have evidence of a physician's order for the CPART holds.

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Bldg. #17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV 89102 89146 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID מו (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 325 Continued From page 22 S 325 Patient #1 Patient #1 was a 13 year old white juvenile admitted to the facility on 02/03/09 with a diagnosis that included bipolar disorder. oppositional defiant disorder and impulse control disorder. The patient was discharged from the facility on 07/23/09. A Physicians Discharge Summary dated 07/23/09 indicated the patient struggled throughout the time in the residential program. On admission the patient was extremely oppositional and labile. Several outbursts required physical holds including the day of admission. A Residential Treatment Center Services Continued Stay Request Note dated 04/15/09 and 06/15/09 indicated the patient was physically restrained for aggressive and violent behaviors on the following dates: 1. 02/03/09 - Physical restraint for aggressive violent behaviors. 2. 02/09/09 - Physical restraint for violent behaviors and attempting to harm staff. 3. 04/13/09 - Physical restraint for aggressive behaviors and attempting to harm staff. 4. 06/15/09 - Physical restraint for aggressive behavior towards a peer. 5. A Nursing progress Note dated 6/17/09 at 1:07 PM, indicated the patient was placed in a physical restraint for being verbally and physically aggressive. A review of Physician Orders from the date of admission on 2/3/09 to the date of discharge on

Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD, Bldg. #17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV .89102~ SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** DEFICIENCY) S 325 Continued From page 23 S 325 7/23/09 revealed one documented physician order for physical restraint for aggressive and violent behavior on 2/3/09. There were no other documented physician orders for restraint use. On 8/24/09 at 4:00 PM, Employee #2 acknowledged there was no documented physician's orders in the medical record for physical restraint use on the patient for 2/9/09, 4/13/09, 6/15/09 and 6/17/09 per facility policy. Employee #2 acknowledged there was no Restraint Incident Reports or Denial of Rights Forms for physical restraint use on Patient #1 for 2/9/09, 4/13/09, 6/15/09 and 6/17/09 per facility policy. The facility Restraint Seclusion Policy last revised 07/06 indicated restraint and seclusion shall only be used in an emergency safety measure in situations of imminent danger to patients, staff or others when less restrictive measures have been or likely to be ineffective in averting danger. Patient #9 Patient #9 was initially admitted on 2/27/09 with the diagnoses that included depressive disorder. post traumatic stress disorder, significant allergies, history of seizures, and history of asthma. Patient #9 was re-admitted to the facility on 7/1/09 with diagnoses including mood disorder, conduct disorder, alcohol abuse, marijuana abuse, history of asthma, and severe constipation. On 8/7/09 at 4:55 PM, a physician's order was received to "Place patient in seclusion for homicidality toward peers." The facility did not produce a DOR or an assessment of the patient for this incident. The facility did not produce

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

HPKN11

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS2128HOS

B. WING \_\_\_

08/27/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## **DESERT WILLOW TREATMENT CENTER**

6171 W CHARLESTON BLVD, Blog. #17 LAS VEGAS, NV 89102 89146

DESERVI	LAS VEG	AS, NV <del>-891</del>	<del>02</del> 89/46	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 325	Continued From page 24	S 325	S 328 - Physical Restraint Use	
	documentation of seclusion monitoring. At 6:55 PM, a physician's order was received to "continue seclusion for secondary for safety of patients and staff."  Review of an incident report dated 8/7/09, revealed that Patient #9 was placed in locked seclusion from 5:00 PM until 9:00 PM for threatening to kill a peer. There was no documentation of how the staff "escorted" Patient #9 to seclusion. There was no documented evidence of VS completed after two hours, a restraint seclusion form for the CPART, or DOR for chemical restraint for the medication given at 6:15 PM. The client notes documented Patient #9 was told to stop hitting the quiet room door at 6:00 PM or she would get a shot. On 8/7/09 at 6:15 PM, a physician's order was received for "Ativan 4 mg IM now for aggression." There was no documented evidence a complete physical assessment was completed after the restraint was implemented. Patient #9 did not participate in the debriefing. The documentation for actions that may be useful for future prevention included		DWTC will consistently follow the hospital's restraint policy and procedures by notifying a physician within one hour after the use of a physical restraint to obtain a physician order (Patient #1 was discharged; Patients #5, #6, #7, and #8 remain in inpatient treatment at DWTC). Nurse supervisors will monitor compliance with the use of physical restraints for all patients, particularly the medical records of Patients #5 - #8.  1. Administration and supervisors enforce policy to ensure the use of physical restraints is executed properly through clinical meetings, supervision, and shift change.  All physical restraints are applied and continued pursuant to an order by the physician. Because physical restraint use is limited to emergencies, qualified, trained staff members (RN) may initiate a restraint before an order is obtained from the physician.  As soon as possible, but no longer than one hour after the initiation of a restraint, RN does the following: Notifies and obtains an order (verbal or written) from the physician. Documents order in medical record. Consults with the physician about	09/04/09
	"no suggestions at this time except discharge from unit."  Complaint #NV00022688		the patient's physical and psychological condition.  2. Administration, supervisors, and peer trainers conduct staff in-service/training to ensure use of physical restraints is properly upheld.	
	Severity: 3 Scope: 3		Retrain staff on Restraint/Seclusion of Patients policy.	10/29/09
S 328 SS=E	NAC 449.3628 Physical Restraint Use  6. If the use of physical restraints is permitted pursuant to approved protocols, the approved protocols must include:  (c) A provision for notifying the physician within 12 hours after the use of the physical restraints is initiated	S 328	Retrain staff on Incident/Accident Reporting policy.  3. Monitor compliance that proper use of physical restraints is upheld.	10/29/09

08/27/2009

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** 

(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING\_

(X3) DATE SURVEY COMPLETED

**NVS2128HOS** 

STREET ADDRESS, CITY, STATE, ZIP CODE

6171 W CHARLESTON BLVD. Bldn.#17

DESERT	DESERT WILLOW TREATMENT CENTER 6171 LAS Y			171 W CHARLESTON BLVD, Bldg.#17 AS VEGAS, NV- <del>89102</del> 89146			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL TON)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
S 328	Continued From page 25  Based on interview, record review and do		S 328	Mandate review of all policies pertaining to physical restraints (annually and upon each revision).	10/29/09		
,	review the facility failed to consistently fol facility restraint policy and procedure and physician within 12 hours after the use of physical restraint for 5 of 11 patients. (Pa #1, #5, #6, #7, and #8)	notify a		Create and institute signed Statement of Understanding of having read, understood, and will adhere to all policies and procedures pertaining to physical restraints.	10/29/09		
!	Complaint #NV00022688			Develop database to track signed statements.	10/15/09		
6 220	Severity: 2 Scope: 2		0.000	Rounding Sheet completed by nurse supervisors has been implemented. This includes direct observation of the use of physical restraints on each unit (at least 2x per shift @ random times). Nurse supervisors will monitor medical records for	10/08/09		
S 329 SS=E	6. If the use of physical restraints is perm pursuant to approved protocols, the approprotocols must include: (d) A requirement that a verbal or written	oved order of	S 329	obtained physician order within one hour after the initiation of a physical restraint. If any violation of the policy or procedures is observed, there will be immediate follow-up of corrective procedures.  Rounding Sheet is reviewed daily by DON and CPM II for oversight and compliance.	1		
	the physician be obtained and entered int medical record of the patient This Regulation is not met as evidenced Based on document review and record refacility nursing staff failed to consistently overbal or written physician orders for all ir of restraint use and document the orders patients medical records for 5 of 11 paties (Patients #1, #5, #6, #7, #9)	by: eview the obtain estances in the		Nurse supervisors receive from unit charge nurses completed Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan for each restraint and seclusion by the end of shift incident occurred. Forms are reviewed for accuracy and completeness. If any error is detected, there will be immediate follow-up of corrective action. Forms are submitted daily to DON for review and oversight.	09/21/09		
	Complaint #NV00022688 Severity 2 Scope 2			Nurse supervisors under the direction of the DON will conduct monthly medical record audits to monitor use of restraints and seclusion, physician	11/20/09		
S 332 SS=F	NAC 449.3628 Physical Restraint Use		S 332	orders obtained and documented, length of restraints and seclusion, medications administered			
JJ-1	8. The hospital shall have a process for q improvement to identify appropriate oppo for reducing the use of physical restraints process for quality improvement must include a for measurement and assessment	rtunities . The lude to		and documented, reasons and results of medication documented in MAR, patient/staff injury, denial of rights, debriefing, post intervention assessment, pain assessment, content of patient progress notes, etc. Audit information will be submitted to the Quality Assurance Department for assessment.			

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Bldg.#17 DESERT WILLOW TREATMENT CENTER LAS VEGAS, NV -89102 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) \$ 332 Data will be presented to monthly LET meetings S 332 Continued From page 26 for quality and program improvement. identify opportunities to reduce the risks associated with the use of physical restraints S 329 - Physical Restraint Use through the introduction of preventive strategies, innovative alternatives to the use of physical DWTC will consistently obtain verbal or written restraints and improvements to the process of physician orders for all instances of restraint use and document the orders in the patients' medical using physical restraints. records (Patient #1 was discharged; Patients #5, #6, #7, and #9 remain in inpatient treatment at This Regulation is not met as evidenced by: DWTC). Nurse supervisors will monitor Based on interview, document review and chart compliance with the use of restraints for all patients, particularly the medical records of review the facility failed to ensure an effective Patients #5, #6, #7, and #9. process through quality assurance for reducing the use restraints through the introduction of 1. Administration and supervisors enforce policy preventative strategies and the provision on to ensure the use of restraints are executed and innovative alternatives and failed to have a plan documented properly through clinical meetings, to reduce the number of physical and chemical supervision, and shift change. restraints. 09/04/09 As soon as possible, but no longer than one hour Severity: 2 Scope: 3 after the initiation of a restraint, the RN notifies and obtains an order (verbal or written) from the physician and documents order in medical record. S 602 S 602 NAC 449.394 Psychiatric Services SS≃I 2. Administration, supervisors, and peer trainers 3. A hospital shall develop and carry out policies conduct staff in-service/training to ensure use and and procedures for the provision of psychiatric documentation of restraints are properly upheld. treatment and behavioral management services 10/29/09 that are consistent with NRS 449.765 to 449.786, Retrain staff on Restraint/Seclusion of Patients policy. inclusive, to ensure that the treatment and services are safely and appropriately used. The Retrain staff on Incident/Accident Reporting hospital shall ensure that the policies and 10/29/09 policy. procedures protect the safety and rights of the

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on staff interview and record review, the

facility policy Restraint/Seclusion of Patients

policy #8.03 dated 1/1/2005 and reviewed on

7/2006 for 5 of 11 patients. (Patients #5, #6, #7,

administration of a chemical restraint and failed to complete a Denial of Rights in accordance with

facility failed to monitor and assess the

patient.

#8, and #9)

HPKN11

10/29/09

10/29/09

3. Monitor compliance that use and documentation

Mandate review of all policies pertaining to

restraints (annually and upon each revision).

Understanding of having read, understood, and

Create and institute signed Statement of

will adhere to all policies and procedures

of restraints are properly upheld.

Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Play.#17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV 89102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 602 Continued From page 27 S 602 pertaining to restraints. Develop database to track signed statements. Patient #9 10/15/09 Rounding Sheet completed by nurse supervisors 10/08/09 Patient #9 was initially admitted on 2/27/09 with has been implemented. This includes direct the diagnoses that included depressive disorder. observation of the use of restraints on each unit (at least 2x per shift @ random times). Nurse post traumatic stress disorder, significant supervisors will monitor medical records to ensure allergies, history of seizures, and history of physician order is obtain and documented within asthma. Patient #9 was re-admitted to the facility one hour after the initiation of a restraint. If any on 7/1/09 with diagnoses including mood violation of the policy or procedures is observed, there will be immediate follow-up of corrective disorder, conduct disorder, alcohol abuse, procedures. Rounding Sheet is reviewed daily by marijuana abuse, history of asthma, and severe DON and CPM II for oversight and compliance. constipation. 11/20/09 Nurse supervisors under the direction of the DON On 7/13/09 at 5:35 PM, a physician's order was will conduct monthly medical record audits to received for "Ativan 2 mg IM STAT for increase monitor use of restraints and seclusion, physician anxiety per patient request." The facility did not orders obtained and documented, length of restraints and seclusion, medications administered produce a DOR for a chemical restraint or an and documented, reasons and results of medication assessment of Patient #9 for this incident. documented in MAR, patient/staff injury, denial of rights, debriefing, post intervention assessment, On 7/13/09 at 6:30 PM, a physician's order was pain assessment, content of patient progress notes, etc. Audit information will be submitted to the received for "Benadryl 50 mg IM now for increase Quality Assurance Department for assessment. anxiety. And may give another dose of Ativan 2 Data will be presented to monthly LET meetings mg IM if patient still anxious/agitated." The for quality and program improvement. facility failed to produce a DOR for a chemical restraint or an assessment of the patient for this S 332 - Physical Restraint Use incident. DWTC is developing an effective process through On 7/13/09 at 9:30 PM, a physician's order was quality assurance for reducing the use of restraints received for "Ativan 2 mg by mouth x 1 dose due via the introduction of preventative strategies and the provision of innovative alternatives. DWTC is to patient refused to take the Seroquel 100 mg." developing a plan to reduce the number of physical The facility failed to produce a DOR for a and chemical restraints. chemical restraint or an assessment of the patient for this incident. The Quality Assurance Specialist will enhance the 11/20/09 tracking method of physical and chemical On 7/14/09 at 9:15 AM, a physician's order was restraints by identifying specific trends and factors precipitating and resulting from restraints. In received for "Ativan 2 mg IM x 1, Benadryl 50 mg doing so, the Quality Assurance Specialist will IM x 1 for aggressive behavior, therapeutic continue to consult with the Medical Director and restraint x 30 minutes or till patient calms down." Director of Nursing (DON) to operationally define The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER!** COMPLETED A. BUILDING B. WING NVS2128HOS 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Bldg. #17 LAS VEGAS, NV 89102 8146 DESERT WILLOW TREATMENT CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 602 Continued From page 28 S 602 trends and factors related to restraints. incident. The identification of specific trends and factors 12/31/09 related to physical and chemical restraints will On 7/14/09 at 10:00 AM, a physician's order was assist DWTC in developing preventive strategies received for "Ativan 5 mg IM x 1 severe and innovative alternatives to the use of restraints and also for improving the process of using aggression, patient kept in locked seclusion due to severe aggression for safety issue." The facility did not produce a DOR for chemical restraint or The Quality Assurance Specialist will report 01/29/10 an assessment of the patient for this incident. identified trends and factors resulting from physical and chemical restraints to the monthly LET meeting. LET will utilize data to determine On 7/14/09 at 8:00 PM, a physician's order was preventive strategies and alternatives to the use of received for "Haldol 5 mg IM STAT and Benadryl restraints and also for improving the process of 50 mg IM STAT for increase anxiety." The 15 using restraints. minute monitor log (DWTC Form #33) documented 22 oppositional behavior episodes The Quality Assurance Specialist has begun to from 7:00 AM to 2:45 PM and 12 episodes of 11/13/09 improve and build upon the process of tracking aggressive behavior documented for same time patient injuries during Conflict Prevention and Response Training (CPART) holds and seclusions. period. The facility did not produce a DOR for a The method is improving from tracking whether or chemical restraint or an assessment of the not an injury had occurred to tracking specific patient for this incident. types of injuries (i.e., leg, arm, shoulder, rug burn, On 7/20/09 at 8:00 PM, a physician's order was received for "Haldol 5 mg IM STAT and Benadryl The Quality Assurance Specialist will report the 12/04/09 50 mg IM STAT due to severe specific types of injuries to the monthly LET meeting. LET will utilize data to determine anxiety/agitation/threatening to hurt others." preventive strategies and to assist in developing a The 15 minute monitor log documented 12 plan for reducing the number of restraints. physical and verbal abuse, non-compliant behaviors from 7:00 AM to 2:45 PM and 12 DWTC is developing a plan to reduce the number episodes of aggressive behavior documented for 09/30/09 of physical and chemical restraints. CPART same time period. The facility did not produce a courses for certification and recertification were reviewed and revised to ensure the protection of all DOR for chemical restraint or an assessment of patients. the patient for this incident. CPART courses include increased practice and role 10/29/09 On 7/21/09 at 2:10 PM, a physicians order was modeling (return demonstration) of all approved received for "Benadryl 50 mg IM, Haldol 5 mg IM CPART holds. Courses also include increased STAT x 1 for severe aggressive behavior towards emphasis on preventive techniques and destaff." The 15 minute monitor log documented escalation content (proactive intervention). nine oppositional behavior episodes from 7:00 AM to 2:45 PM and three episodes of aggressive Policies, including the Incident/Accident Reporting 10/15/09 policy and Restraint/Seclusion of Patients policy, behavior documented for same time period. The facility did not produce a DOR for chemical

PRINTED: 09/23/2009

Bureau o	of Health Care Quali	ty & Compliance				FORM	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
	170	NVS2128HOS		B. WING _		08/2	7/2009
NAME OF P	ROVIDER OR SUPPLIER		1		STATE, ZIP CODE		
DESERT	WILLOW TREATMEN	T CENTER	6171 W C	HARLESTOI \S, NV ∙ <del>8910</del>	n blvd <i>, Bldg.#17</i> 89 <i>146</i>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S 602	Continued From pa	_		S 602	were revised for heightened clarity and for protection of all patients.	or the	
	incident. On 7/24/09 at 5:46 received for "CPAR IM Haldol 5 mg/Ber	PM, a physician's or T for patient and standadry! 50 mg IM now	der was iff safety,		A series of mandatory staff in-services we conducted at DWTC to include retraining policies, emphasis on preventive and detechniques, and use of physical and chemical restraints.	g on escalation	10/29/09
	oppositional behavi 10:45 PM and four behavior document facility did not produ	documented seven or episodes from 3:0 episodes of aggress ed for same time pe uce a DOR for a che essment of the patier	ive riod. The mical		The Quality Assurance Specialist will be and reporting specific trends and factors to physical and chemical restraints, inclu involved patients and staff, type of injuri holds, etc. This data will be utilized to d preventive strategies, alternatives, and a reduce the number of physical and chem restraints.	pertaining ding es, type of etermine plan to	01/29/10
	received for "Ativar patient and staff sa log documented tw episodes from 3:00 episodes of aggres	PM, a physician's or 15 mg IM or PO, CP fety." The 15 minute o oppositional behave AM to 10:45 PM an sive behavior docum The facility did not pul restraint.	ART for e monitor vior d six nented for		The CPM II will monitor and ensure that has an effective, comprehensive quality improvement program to evaluate the procare to its patients, as well as an effective reduce the number of physical and chemestraints and also to improve the process restraints.  S 602 – Psychiatric Services	ovision of e plan to ical	01/29/10
	received for "Ativar now agitation." The for a chemical resti patient for this incid		I 5 mg IM uce a DOR ent of the		DWTC will execute policies and proced the provision of psychiatric treatment and behavioral management services to ensu treatment and services protect the safety of all patients (Patients # 5, #6, #7, #8, a remain in inpatient treatment at DWTC) supervisors will monitor the psychiatric all patients, particularly the treatment and	nd and rights and #9 Nurse services of	
	received for "Ativar STAT, agitation." T	0 PM, a physician's on 4 mg IM and Haldo he facility did not properties. The facility did not properties and assess and the facility of the	l 5 mg IM oduce a		records of Patients #5 - #9.      Administration and nurse supervisors polices and procedures to ensure psychitreatment and services protect the safety of all patients through clinical meetings.	s enforce atric and rights	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

On 8/1/09 at 7:10 PM, a physician's order was received for "Ativan 4 mg IM STAT and Haldol 5

at 1:00 PM documented patient to patient

mg IM STAT due to aggressive behaviors and increase agitation." The incident report for 8/7/09

supervision, and shift change.

Nursing staff will consistently obtain physician

orders for all chemical and physical restraints and

09/11/09

Rureau	of Health Care Quali	ty & Compliance					: 09/23/2009 APPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDIN B. WING		(X3) DATE SI COMPLE	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, 8	STATE, ZIP CODE	1 00,2	172000
	WILLOW TREATMEN	NT CENTER	C474 101 O		MANUALL HIT		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S 602	Continued From pa	ge 30		S 602	seclusions per hospital policy.	1	
	physical aggression documented Patien	_			Nursing staff will consistently document physician orders in patients' medical reco		09/11/09
	DOR being complete occurred. There we complete physical at the restraint was important documentation of the quiet room. The DOR for a chemical	ted or a that debriefing as no documented exassessment complete aplemented. There wow the patient was expected in the patient of an asset of a second asset of a second in the product of an asset of a second in the product of an asset of a second in the product of an asset of a second in the product of an asset of a second in the product of an asset of a second in the product of a second in the second in the product of a second in the second in the product of a second in the product of a second in the s	ng had vidence a ed after vas no escorted to uce a	6	Nursing staff will consistently document restraints and seclusions in patients' medi records and through the use of an Inciden Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights and Secsion and Restraint and Secsion and the Restraint and Secsion and Secs	ical t/ form, Pain Seclusion	09/11/09
	received to "Locked homicidal threats, A	ncident. PM, a physician's ord I seclusion secondar Ativan 2 mg po x 1 ac The facility did not p	ry to cute		Nursing staff will consistently complete a rights form for all instances when patient placed in physical restraints and seclusion when chemical restraints are used.  Note: During the September 17, 2009 method Commission on Montel Health and	s are n, and	09/11/09
	DOR for chemical rethe patient for this in the patient for this in On 8/11/09 at 6:00 received for "Thora: increase anxiety an facility did not produrestraint or an asse incident.  On 8/15 at 7:30 PM received for "Thora: facility did not produced for the produc	restraint or an assessincident.  PM, a physician's order to be patient reques uce a DOR for a chessment of the patient reques a physician's order to be patient to be pati	der was for t." The mical of for this was The ical	S	the Commission on Mental Health and Developmental Services, this body comm discuss the Seclusion and Restraint Emer Procedures form in relation to patient der rights at their next meeting scheduled for November 19, 2009. If the intent of the Commission is to continue to utilize the denial of rights, then a request will be minclude "Denial of Rights" in the title of The Commission's authority regarding drights is set forth in NRS 433.534. DWT follow the guidance of the Commission's Attorney General's Office regarding the requirements and the Commission's decitheir statutory authority.	rgency nial of form as a ade to the form. enial of TC will and the reporting sions per	11/19/09
	incident. There was	ssment of the patien s no documented roun n the physician's ord	ute for the		Nursing staff will consistently document medications, one time medications, and medication orders on the MAR.	STAT	10/29/09
					Nursing staff will consistently document	the	i

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Complaint #NV00022688

Patient #7, a 15 year old male, was admitted on 7/10/09, with the diagnoses that included

depressive disorder, history of psychotic disorder,

Patient #7

reasons and results for all IM PRN (intramuscular as needed) medication. The reasons and results will be documented on the back of the MAR and in

the patient's medical record.

10/29/09

08/27/2009

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

**NVS2128HOS** 

B. WING \_\_\_\_\_STREET ADDRESS, CITY, STATE, ZIP CODE

**DESERT WILLOW TREATMENT CENTER** 

6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89 146

DESERI	WILLOW TREATMENT CENTER LAS V	EGAS, NV -891	97 89146	-
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 602	Continued From page 31	S 602	All medications will be documented by name, dosage, time, route, and reason.	10/29/09
	history of impulse disorder, and history of oppositional defiant disorder.  On 7/10/09 at 12:30 PM, a physician's order was		A consent form for all medication will be consistently obtained from parent/legal guardian.	10/29/09
	received for "Haldol 5 mg IM STAT, Ativan 2 mg IM STAT, Benadryl 50 mg IM STAT for severe anxiety and aggressive behavior." The facility d not produce an Incident/Accident report, assessment, nor DOR for this incident. The IM	gid	Nursing staff will consistently complete and document a physical assessment for each occurrence of restraint and seclusion. This will be documented on the Incident/Accident Report and in the patient's medical record.	10/29/09
given; the MA	medications were documented on the MAR as given; nothing was documented on the back of the MAR in the "Reasons and Results" section.		Administrators, supervisors, and peer trainers conduct staff in-service/training to ensure psychiatric treatment and services protect the safety and rights of all patients.	
	On 7/11/09 at 11:27 AM, a physician's order stated "physical restraint up to 2 hours for physical aggression, Haldol 5 mg IM and Benadryl 50 mg IM STAT." The facility did not		Retrain staff on Incident/Accident Reporting policy.	10/29/09
	produce an Incident/Accident report, assessme nor DOR for this incident.	nt,	Retrain staff on Restraint/Seclusion of Patients policy.	10/29/09
	On 7/21/09 at 12:30 PM a physician's order was received for "Haldo! 5 mg IM STAT, Ativan 2 mg		Retrain staff on NAC 449.3628 – Protection of Patients.	10/29/09
	IM STAT, Benadryl 50 mg IM STAT." The facilit did not produce an Incident/Accident report, assessment, nor DOR for this incident. The	У	Retrain staff on NRS Patient Rights 449.700 – 449.730.	10/29/09
	medications were documented on the MAR as given. However, nothing was documented on ti back of the MAR in the "Reasons and Results" section.	he	Monitor compliance that psychiatric treatment and services protect the safety and rights of all patients.	
	On 8/9/09 8:05 PM, an incident report		Mandate review of all policies pertaining to restraints and seclusion.	10/29/09
	documented a "CPART hold, Haldol 5 mg tM, Benadryl 50 mg tM" to be given. The facility did not produce a DOR for this incident.		Create and institute signed Statement of Understanding of having read, understood, and will adhere to all policies and procedures pertaining to restraints and seclusion.	10/29/09
	Patient #8		Develop database to track signed statements.	10/15/09
	Patient #8, a 12 year old male, was admitted or 8/7/09, with a diagnosis of mood disorder.	1	23 The Landace to that digital statement.	

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS2128HOS** 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD , Blog. #17 DESERT WILLOW TREATMENT CENTER LAS VEGAS, NV 89102 89146 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 10/08/09 S 602 Rounding Sheet completed by nurse supervisors S 602 Continued From page 32 has been implemented. This includes direct A registered nurse progress note dated 8/11/09. observation of the use of restraints and seclusion on each unit (at least 2x per shift @ random times). read "Escorted to hallway down to quiet room and If any violation of the policies or procedures is was making negative remarks to staff in an observed, there will be immediate follow-up of intimidating fashion. Given Benadryl IM at 9:15 corrective procedures. Rounding Sheet is AM which he initially refused but with firm reviewed daily by DON and CPM II for oversight and compliance. redirection cooperated with procedure." The facility did not produce an Incident/Accident 09/29/09 Nurse supervisors receive from unit charge nurses report, Assessment, nor DOR for this incident. completed Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of A physician's order dated 8/11/09 at 9:14 AM Rights form, Pain Assessment form, and the read "Benadryl 25 mg IM STAT for severe Restraint and Seclusion Debriefing & Positive anxiety." The MAR provided indicated the Behavior Intervention Plan for each restraint and seclusion by the end of shift incident occurred. Benadryl was given, however there was no Forms are reviewed for accuracy and "Reason and Results" recorded for the completeness. If any error is detected, there will medication. be immediate follow-up of corrective action. Forms are submitted daily to DON for review and oversight. An RN progress note written on 8/13/09 read "He refused to go to Quiet Room, then he postured to 11/20/09 Nurse supervisors under the direction of the DON hit staff with a closed fist. CPART hold was will conduct monthly medical record audits to implemented. Dr. was made aware of the monitor use of restraints and seclusion, physician incident. Benadryl 25 mg IM was ordered and orders obtained and documented, length of was given at 4:50 PM." A physician's order dated restraints and seclusion, medications administered and documented, reasons and results of medication 8/13/09 at 4:45 PM read "CPART ..., Benadryl 25 documented in MAR, patient/staff injury, denial of mg IM Now." The MAR indicated the Benadryl rights, debriefing, post intervention assessment, was given, there was no "Reason and Results" pain assessment, content of patient progress notes, recorded for the medication. There was no etc. Audit information will be submitted to the Quality Assurance Department for assessment. "Denial of Rights" completed for the Benadryl IM. Data will be presented to monthly LET meetings The record did not contain a consent form for the for quality and program improvement. use of the Benadryl. 09/16/09 The Quality Assurance Specialist will compare Patient #5 patient progress notes with database that contains all submitted Incident/Accident Reports and Patient #5, a 16 year old female, had a current Restraints/Seclusions for accurately capturing and appropriately documenting all incidents. Twenty admit date on 6/24/09 and a previous admission patient cases will be randomly selected per quarter. on 5/7/09. Her diagnoses included bipolar Discrepancies will be brought to the attention of disorder, mixed, severe psychosis, eating the CPM II within one business day for further disorder, and post traumatic stress disorder. investigation and corrective action if necessary. Patient #5 was prescribed and given Benadryl 50 mg by mouth as needed for anxiety on 7/6/09 at

Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B, WING **NVS2128HOS** 08/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6171 W CHARLESTON BLVD, Bldg.#17 **DESERT WILLOW TREATMENT CENTER** LAS VEGAS, NV -89102 89146 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 602 Continued From page 33 S 602 5:00 PM; 7/12/09 at 4:30 PM; 7/13/09 at 8:00 PM; 7/14/09 at 8:00 PM; 7/26/09 at 5:30 PM; and 7/30/09 at 4:45 PM. The "Reasons and Results" for the medications were not documented on the back of the MAR. On 5/10/09 at 4:55 PM an incident was documented that "staff held her from 3:55 to 4:55." The description of occurrence section of the report read "at start of shift IM meds to include Ativan, Benadryl and Zyprexa after refused to take PO. Needed PRN meds as she was hitting, kicking ..." On the physician order for 5/10/09, the RN documented "5/10/09 11:45 PM error noted 5/10/09 3:50 PM Benadryl 50 mg and Ativan 1 mg IM STAT." The MAR indicated the Benadryl and Ativan were given at 3:40 PM. No "Reasons and Results" were recorded on the back of the MAR. The July 2009 MAR indicated Benadryl 50 mg PO (orally) PRN was given on six occasions. The "Reason and Results" section of the MAR provided was blank. Patient #6 Patient #6, a 15 year old male, was admitted on 2/2/09, with the diagnosis of psychotic disorder. On 7/3/09 at 9:00 PM an incident was recorded as "CPART hold and Benadryl 50 mg IM STAT. A physician's order on 7/3/09 at 9:00 PM read".... Benadryl 50 mg IM STAT." The MAR did not indicate the Benadryl 50 mg IM STAT was given on 7/3/09 at 9:00 PM. On 7/11/09 at 10:15 AM a physician's order was

PRINTED: 09/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS2128HOS 08/27/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD , Bldg . #17 DESERT WILLOW TREATMENT CENTER LAS VEGAS, NV-89102 89146 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **TAG** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 602 Continued From page 34 S 602 written for "Benadryl 50 mg IM STAT, Haldol 5 mg IM STAT for severe anxiety and physical aggression." The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident. The MAR provided indicated the medications were given. There were no "Reasons and Results" documented on the MAR for the medications. On 7/13/09 at 8:30 PM, an incident was recorded as a "... Benadryl 50 mg, Ativan 2 mg, Haldol 5 mg IM given." There was no physician's order for the Benadryl 50 mg, Ativan 2 mg, or Haldol 5 mg IM. The MAR provided indicated Benadryl 50 mg, Ativan 2 mg, and Haldol 5 mg IM were given at 8:00 PM. On 7/18/09 at 11:55 AM, a physician's order read "CPART hold for physical/violent aggression. Benadryl 50 mg IM STAT, Ativan 2 mg IM STAT, and Haldol 5 mg IM STAT. The Benadryl, Ativan, and Haldol were not on the MAR provided. Interviews with the Director of Nursing (DON) revealed when a IM PRN medication was given the nurses (RN) were to record the "Reasons and Results" on the back of the MAR. An interview on 8/25/09 at 2:45 PM with a unit RN revealed the nurses did not always document the "reasons and results" of PRN medication on the MAR.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

An interview on 8/26/09 at 10:30 AM with another RN revealed he would complete the "reasons and results" on the MAR if the medication was an antipsychotic or an intramuscular administration.

Severity: 3 Scope: 3